Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMPREHENSIVE PAIN MANAGEMENT
5734 SPOHN DRIVE SUITE A
CORPUS CHRISTI TX 78414

Respondent Name
LUMBERMENS MUTUAL CASUALTY CO

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-09-6030-01

MFDR Date Received
FEBRUARY 10, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physician saw the patient for an office visit for his compensable injury. According to TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury. See copy of previous EOB (dos 06/18/08) from carrier paying for J7799, 62368, 77002, and 95990. Patient has an intraspinal pump surgically implanted inside of him which delivers medications to him intraspinally for pain relief."

Amount in Dispute: $1,360.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**The EOBs raise underlying issues of causal relation**. In particular, the EOBs indicate the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury…Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2008	CPT Code 62368	$67.35	$ 0.00
	CPT Code 95990	$75.33	$ 0.00
	CPT Code 77002	$92.73	$ 0.00
	CPT Code J7799	$1,125.00	$ 0.00
TOTAL		$1,360.41	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 29, 2008
   - W12-Extent of injury. Not finally adjudicated.

   Explanation of benefits dated September 3, 2008, September 27, 2008 and October 22, 2008
   - 219-Based on extent of injury.

Issues

1. Does the documentation support an extent of injury issue exist in this dispute?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason codes "W12-Extent of injury. Not finally adjudicated, and 219-Based on extent of injury."

   On July 23, 2007, a Benefit Dispute Settlement was reached that states "The parties agree that the date of injury of June 27, 2001 does not extend to or include the cervical spine (neck) or bilateral carpal tunnel syndrome."

   The Division finds that the primary diagnosis listed on the submitted bill for the disputed services is ICD-9 code 723.1-Cervicalgia. Therefore, the documentation supports that an extent of injury issue exists in this dispute.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that the Benefit Settlement Agreement found that the compensable injury does not extend to the cervical spine, therefore, the dispute was not filed in accordance with 28 Texas Administrative Code §133.305 and §133.307.
3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/10/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.